

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Josephine Cabal (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 2322 Awapuhi Street #1, Hilo, Hawaii 96720	Inspection Date: May 28, 2019

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> Substitute care giver (SCG) #1, no care giver training provided by the primary care giver (PCG) to administer medications.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>YES, CONTINUING EDUCATION AND TRAINING COMPLETED.</i></p>	<p><i>5/29/19</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> Substitute care giver (SCG) #1, no care giver training provided by the primary care giver (PCG) to administer medications.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>TO AVOID THIS ISSUE IN THE FUTURE, I WILL REVIEW ALL SUBSTITUTES RECORDS FOR REQUIREMENTS AS STATED IN CHAPTER H-100.1-9 (c)(4), MONTHLY FOR COMPLETENESS. I WILL SET UP A TRIGGER LIST TO ALERT MYSELF FOR UPDATES ON REQUIREMENTS AS NEEDED.</p>	<p>5/29/19</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1, physician order dated November 27, 2018 read:</p> <ul style="list-style-type: none"> • “Furosemide 20 mg Tablet Dosage: 1 (one) Tablet (Oral) daily on Mon, Wed, Friday for swelling in legs, <u>hold if blood pressure low SBP<140</u> or if patient feels weak.” <p>However, no blood pressure documented prior to administration.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #1, physician order dated February 12, 2019 read, "Thick-it to thicken liquids." And after visit summary noted "Recommend nectar thick." Thickening agent not documented on February – May 2019 medication records as administered.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>YES, CORRECT ORDER WAS OBTAINED FOR THE THICKENING AGENT FROM THE PRIMARY PHYSICIAN ON 5/30/2019. THICKENING AGENT IS DOCUMENTED IN THE MEDICATION ADMINISTRATION RECORD.</p>	<p>5/30/19</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (1) In addition to the requirements in subchapter 2 and 3:</p> <p>A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;</p> <p><u>FINDINGS</u> SCG #2, no care giver training to administer oral medications and "finger stick glucose check" provided by case manager.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>YES, CONTINUING EDUCATION AND TRAINING COMPLETED.</i></p>	<p><i>5/29/19</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (1) In addition to the requirements in subchapter 2 and 3:</p> <p>A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;</p> <p><u>FINDINGS</u> SCG #2, no care giver training to administer oral medications and "finger stick glucose check" provided by case manager.</p>	<p>PART 2</p> <p>FUTURE PLAN</p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>TO AVOID THIS IN THE FUTURE, I WILL REVIEW ALL SUBSTITUTE RECORDS WITH THE CASE MANAGER FOR REQUIREMENTS AS STATED IN CHAPTER 11-100.1-83, TEACHING WILL BE DONE ON ADMISSION OF ALL SUBSTITUTES. A CHECKLIST WILL BE FORMULATED AS A REMINDER OF REQUIRED TRAINING.</p>	<p>✓</p> <p>5/30/19</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-84 <u>Admission requirements.</u> (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information:</p> <p>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs.</p> <p><u>FINDINGS</u> Resident #1, no influenza vaccination.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>YES, CLARIFY WITH THE PHYSICIAN COMPLETED ^{ON} 5/30/19.</p>	<p>5/30/19</p>

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Licensee's/Administrator's Signature: Josephine Cabal

Print Name: JOSEPHINE CABAL

Date: 5/31/2019